APPLICATION FOR A LICENSE AS A RESPIRATORY CARE PRACTITIONER

State Form 43825 ((R3 / 5-01)
Approved by State Board of Accounts, 2001

HEALTH PROFESSIONS BUREAU
402 W. Washington Street, Room 041
Indianapolis, IN 46204

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

APPLICATION FEE	
DATE FEE PAID	
RECEIPT NUMBER	
LICENSE NUMBER	
LICENSE ISSUE DATE	
PERMIT NUMBER	
PERMIT ISSUANCE DATE	

APPLICANT

Attach one (1) passport type quality photograph of yourself taken within the last eight weeks.

DO NOT WRITE ABOVE THIS LINE. FOR OFFICE USE ONLY.

PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number *
Address (*number and street, or rural route*)		
City	State	ZIP code
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Telephone number (*daytime*)	E-mail address	

BASIS FOR LICENSURE
(*Please check one***)**

☐ **EXAMINATION**	Based upon applying to take the NBRC Examination.
☐ **ENDORSEMENT**	Based upon being licensed in another state or coming from a state that does not license or certify but is credentialed by the NBRC.
☐ **CREDENTIALS**	Based upon your NBRC Certification only. (*You may not apply based upon credentials if you are licensed or certified in another state or are coming from a state that does not license or certify respiratory care practitioners.*)

TEMPORARY PERMIT INFORMATION

Do you wish to have a temporary permit issued pending your application for licensure? ☐ Yes ☐ No

GRADUATE OF A SCHOOL OR PROGRAM OF RESPIRATORY CARE

NAME OF SCHOOL	LOCATION OF SCHOOL	DATE OF GRADUATION

EXAMINATION RECORD

EXAMINATION TAKEN	DATE OF MOST RECENT EXAMINATION (*month, day, year*)	WHERE TAKEN	HOW MANY TIMES HAVE YOU SAT FOR THIS EXAMINATION
National Board for Respiratory Care (NBRC)			
Other _____			

UNDERGRADUATE AND GRADUATE TRAINING

NAME OF SCHOOL	LOCATION OF SCHOOL	DATES ATTENDED	DEGREE GRANTED

STATES LICENSED

Do you hold or have you ever held, a license, certificate, registration or permit to practice any regulated health occupation? ☐ **Yes** ☐ **No**
If yes, please list all states, including Indiana, in which you have been licensed to practice as a Respiratory Care Practitioner, or any other health related occupation.

LICENSE TYPE	STATE	NUMBER	DATE ISSUED	EXPIRATION DATE	STATUS

LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION

GENERAL LOCATION	DATES

LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION

NAME OF EMPLOYER AND ADDRESS	RESPONSIBILITIES	DATES OF EMPLOYMENT

If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details; include the violation, location, date and disposition. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana?	☐ Yes ☐ No
2. Has disciplinary action ever been taken regarding any license, certificate, registration or permit you hold or have held?	☐ Yes ☐ No
3. Have you ever been denied a license, certificate, registration or permit to practice respiratory care or any regulated health occupation in any state (*including Indiana*) or country?	☐ Yes ☐ No
4. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem?	☐ Yes ☐ No
5. Have you ever been convicted of, plead guilty or nolo contendre to: A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*.)	☐ Yes ☐ No ☐ Yes ☐ No
6. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes ☐ No
7. Have you ever been admonished, censured, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes ☐ No
8. Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for a license to practice respiratory care.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

A photostatic copy of this authorization has the same force an effect as the original.

AFFIRMATION

I hereby swear or affirm, that I have read the above statements and agree to the same.

Signature of applicant	Date signed (*month, day, year*)

VERIFICATION OF LICENSURE
RESPIRATORY CARE PRACTITIONER

INSTRUCTIONS: Please complete the top portion of the verification and send a copy to each state where you hold or have held a license. Request each state to complete and send directly to:

HEALTH PROFESSIONS BUREAU
402 West Washington Street
Room 041
Indianapolis, Indiana 46204
(317) 232-2960

APPLICANT INFORMATION

Name (*last, first, middle, maiden*)		Social Security number *
Address (*number and street, or rural route*)		
City	State	ZIP code
Date of birth (*month, day, year*)	Telephone number (*daytime*)	E-mail address

I hereby authorize the State of _____, to furnish the Health Professions Bureau of Indiana with the information below.

Signature	Date signed (*month, day, year*)

TO BE COMPLETED BY THE STATE BOARD

License number	Date of issuance	Expiration date

License issued based upon:

☐ Examination ☐ Endorsement ☐ National Board of Respiratory Care (NBRC) Credential
☐ Other: _____

Type of examination:	Date of examination(s)
☐ NBRC ☐ State Constructed Examination (*Attach subjects, scores and average*)	

Has this license been subject to any disciplinary action?
(*Please attach certified copies of any disciplinary action taken by your board.*) ☐ Yes ☐ No

FORM COMPLETED BY:

Name	**PLEASE AFFIX BOARD SEAL**
Title	
State Board	
Date (*month, day, year*)	